A. General Requirements

According to HSS 107.02 (3), Wis. Admin. Code, Wisconsin Medicaid requires prior authorization for certain services for the following reasons:

- ✓ Safeguard against unnecessary or inappropriate care and services.
- ✓ Safeguard against excess payment.
- ✓ Assess the quality and timeliness of services.
- ✓ Determine if less expensive alternative care, services, or supplies are usable.
- ✓ Promote the most effective and appropriate use of available services and facilities.
- ✓ Curtail misuse practices of providers and recipients.

Providers need prior authorization for certain specified services *before* delivery unless the service is an emergency. Payment is not made for services provided either before the grant date or after the expiration date indicated on the approved prior authorization request form. If the provider provides a service which requires prior authorization without first obtaining prior authorization, the *provider* is responsible for the cost of the service.

Prior authorization does not guarantee payment. Provider eligibility, recipient eligibility, and medical status on the date of service, and all other Medicaid requirements must be met before the claim is paid.

B. Services Requiring Prior Authorization

When Wisconsin Medicaid Requires Prior Authorization

Wisconsin Medicaid applies the same prior authorization requirements for all therapy providers:

1. Wisconsin Medicaid requires prior authorization for therapy services received from any provider in the recipient's lifetime in excess of 35 days per spell of illness (SOI) (HSS 107.16 (2), HSS 107.17 (2), and HSS 107.18 (2), Wis. Admin. Code).
2. For conditions that do not qualify for an SOI, Wisconsin Medicaid requires prior authorization starting with the first day of treatment.

   Examples include:

   - ✓ Decubitus ulcers.
   - ✓ Mental retardation.
   - ✓ Aural rehabilitation following cochlear implant (includes evaluation of aural rehabilitation status and hearing therapeutic services) with or without speech processor programming.
   - ✓ Modification of voice prosthetic or augmentative alternative communication device to supplement oral speech.
3. Wisconsin Medicaid also requires prior authorization starting with the first day of treatment for other circumstances including:

   - ✓ Co-treatment (interdisciplinary treatment).
   - ✓ Procedures shown as unlisted (non-specific) procedures as identified in Medicaid therapy publications.

B. **Services Requiring Prior Authorization** (continued)

Requirements for Electrical Stimulation as Treatment for Decubitus Ulcers

Decubitus ulcers do not qualify as an SOI. When requesting prior authorization for electrical stimulation as treatment for decubitus ulcers, request the service as a manual electrical stimulation procedure. Payment is made only for the face-to-face time that the PT is in attendance.

The prior authorization request must include all of the following documentation:

- ✓ The character, size, etc., of the pressure sore.
- ✓ Weekly measurements.
- ✓ Weekly percentage change in size or healing.
- ✓ The need for additional time for dressing changes or preparation time.

Prior authorization for continuing treatment is considered if formation of granulation tissue or a 25 percent reduction in area has occurred within 45 treatment days. Documentation of nursing protocols, positioning recommendations, and dietary involvement is required when this rapid improvement has not occurred within 45 days.

Co-Treatment (Interdisciplinary Treatment)

All co-treatment requires prior authorization. Each provider involved in co-treatment must complete a separate prior authorization request that identifies the other co-treatment provider and documents the medical necessity of co-treatment. Refer to Section II of this handbook for additional information on covered services.

Co-treatment is approved *only under extraordinary circumstances*. Requests for co-treatment must include documentation justifying why individual treatment from a therapist does not provide maximum benefit to the recipient and why two different kinds of therapy (treating simultaneously) are required. Wisconsin Medicaid recognizes that physical therapy, occupational therapy, and speech pathology each provide a unique approach to the individual's treatment. BHCF medical consultants review all prior authorization requests for co-treatment.

Other Circumstances

Providers should request prior authorization for all services provided to recipients who currently receive, or have previously received, physical therapy services from another certified provider to avoid denial for duplication of services. For example, payment is denied when another provider has a valid prior authorization for therapy services or when payment for physical therapy services is received by another provider under a recipient's first or subsequent SOI.

Physical Therapy Services Provided by Outpatient Hospital Facilities and Home Health Agencies

Prior authorization requirements *in this section* do not apply to *onsite* hospital services and home health agencies. Hospital *offsite* services follow prior authorization and other requirements in this handbook. Refer to the hospital handbook (Part F) for more information about other requirements beyond prior authorization. Physical therapy services provided by a home health agency are subject to other prior authorization requirements under HSS 107.11 (3), Wis. Admin. Code. Refer to the home health handbook (Part L, Division II) for more information about home health physical therapy services.

C. General Prior Authorization Requirements

The following are general prior authorization requirements for physical therapy services:

- ✓ The prior authorization request form must be complete and must contain sufficient information to clearly describe the medical necessity of the services.
- ✓ The services must comply with all state and federal regulations.
- ✓ The attachments, if submitted with the prior authorization request, must have the current date, recipient's name and identification number on each page, and be stapled to the prior authorization forms. Attachments may only supplement the information requested on the forms. The attachments *are not* a replacement for the prior authorization request forms.

Refer to Appendices 9, 9a, 10, and 10a of this handbook for more information.

D. Other Limitations

As specified in HSS 107.16 (3) (e), Wis. Admin. Code, extension of therapy services (e.g., additional therapy services) is not approved beyond the 35 treatment-day prior authorization threshold per SOI in any of the following circumstances:

- ✓ The recipient shows no progress toward meeting or maintaining established and measurable treatment goals over a six-month period. Or, the recipient shows no ability within six months to carry over abilities gained from treatment in a facility to the recipient's home.
- ✓ The recipient's chronological or developmental age, way of life, or home situation, indicates the stated goals are not appropriate for the recipient or serve no functional or maintenance purposes.
- ✓ The recipient has achieved independence in daily activities or can be supervised and assisted by restorative nursing personnel.
- ✓ The evaluation indicates the recipient's abilities are functional for the recipient's present way of life.
- ✓ The recipient shows no motivation, interest, or desire to participate in therapy, which may be for reasons of an overriding severe emotional disturbance.
- ✓ Other therapies are providing sufficient services to meet the recipient's functioning needs. Or, the procedures are one of the following:
  - → Not medical in nature.
  - → Experimental or research.
  - → Noncovered services.
  - → Determined by Wisconsin Medicaid to be medically unnecessary.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA)

- ✓ The prior authorization request form must be filled out completely (i.e., all sections completed). The request and attached documents must include the following:
- ✓ The request must be accompanied by a physician's signature (a copy of the physician's order sheet dated within 90 days of its receipt by the fiscal agent indicating the physician's signature is acceptable). If the required documentation is missing from the request form, the request is returned to the provider for the missing information.

E. Completion of Prior Authorization Request Form (PA/RF) and Prior Authorization Therapy Attachment Form (PA/TA) (continued)

- ✓ A written report of the evaluation results and recommendations must be attached to the prior authorization request.
- ✓ The treatment plan must contain specific measurable goals including written instructions for follow-through or carryover by the recipient and/or caregiver. Carryover or follow-through is to be realistically achievable by the recipient and/or caregiver both at the place of residence for a recipient and other programs (e.g., in a facility for the developmentally disabled, nursing home, sheltered workshop, etc.). If carryover is not possible within six months of initiating treatment, continued authorization per the Wisconsin Administrative Code may not be approved.
- ✓ Progress statements must include information relating to progress in motor, sensory integrative and cognitive areas, and performance of independent living/ functional skills. Progress statements must be specific, objective, and measurable.
- ✓ If therapy is being requested for a school-age child *outside of* or *in addition* to school system therapy, the following must be included:
  - → A copy of the therapy IEP and the comprehensive therapy evaluation contained in the M-Team Report must be attached to the prior authorization request for the purpose of coordination and integration of the educational and medical needs of the child.
  - → If no therapy IEP or IEP M-Team therapy evaluation exists, information justifying the reason for the absence of school therapy must be submitted.
  - → Documentation substantiating the medical necessity of proposed therapy and the procedure for coordinating the treatment plan between therapists must be submitted.
- ✓ If therapy is requested for a recipient in a facility for the developmentally disabled (FDD), a copy of the Interdisciplinary Program Plan (IPP) must be attached to the prior authorization request to document coordination and integration of the active treatment and medical care plan of the recipient.
- ✓ Indicate the requested start date for therapy services to the right of element 24 on the PA/RF form.

F. Modifiers

Medicaid Modifier for Physical Therapy Procedure Codes

PTs, rehabilitation agencies, and therapy groups must add modifiers when requesting prior authorization for *all* physical therapy services.

Modifiers allow therapists and Wisconsin Medicaid to distinguish between physical and occupational therapy services with identical procedure codes. The modifier for physical therapy procedure codes is "PT."

How to Request Prior Authorization Using Modifiers

Enter the "PT" modifier on the PA/RF, in addition to all the other required elements, for physical therapy services under the new coding structure.

Refer to Appendices 9 and 9a for a PA/RF claim form sample and PA/RF completion instructions.

F. Modifiers (continued)

How to Request a New Spell of Illness (SOI) Using Modifiers

Include elements 14-19 on the PA/RF when requesting approval of a new SOI for physical therapy services under the new coding structure. This is in addition to all other required elements on the PA/RF. Refer to Appendices 11 and 11a for a PA/RF SOI sample and completion instructions.

SOIs authorized under deleted codes are not paid for dates of service after December 31, 1995.

You must amend PA/RFs with a Prior Authorization Spell of Illness Attachment (PA/SOIA) for dates of service after December 31, 1995. Amend the PA/RF by using the new coding structure and adding PA/RF elements 14 - 19 or complete a prior authorization request under the new coding structure. Refer to Appendices 12 and 12a for a PA/SOIA sample and completion instructions.

G. Additional Information Relating to Prior Authorization

Section VIII of Part A, the all-provider handbook, identifies procedures for obtaining prior authorization including emergency situations, appeal procedures, transferring authorization, supporting materials, retroactive authorization, recipient loss of eligibility midway in treatment, and prior authorization for out-of-state providers.

Multiple Providers

If more than one physical therapy provider from different agencies requests dual-treatment for one recipient, each provider must complete a separate PA/RF. The BHCF processes the requests *at the same time*. In addition to completion of the required prior authorization elements, include the following information:

- ✓ The reason for the dual-certification.
- ✓ The specific days of the week each provider administers the service.
- ✓ The procedure for the coordination of the treatment plan.

Change of Provider

An approved prior authorization may be transferred by the fiscal agent from the provider who obtained the approved prior authorization to another provider. The transfer may occur when medically necessary and when new ownership of a provider or a change in the billing provider number occurs. In all other circumstances when a recipient goes to a new provider, a new prior authorization must be requested.

The provider requesting transfer of the prior authorization must send all of the following to the fiscal agent:

- ✓ A copy of the current PA/RF.
- ✓ A new PA/RF which is *completely* filled out and indicates the "new" provider's name and provider number.
- ✓ A cover letter attached to the packet of PA/RFs that the provider sends to the fiscal agent. The cover letter must include the following information:
  - → The specific reason for the change of provider.
  - → The previous provider's name.

G. Additional Information Relating to Prior Authorization (continued)

- ➔ The new provider's name and provider number.
- ➔ The effective date of the transfer.

Providers must observe professional courtesy by sharing information for administrative purposes. The expiration date of the current prior authorization and the grant date of the new prior authorization are based on the effective date in the cover letter.

Review of Prior Authorization Decisions

When a provider disagrees with a prior authorization disposition, the provider may request an informal review by one of several methods:

- ✓ If a prior authorization has been approved with modification, submit a letter to amend the therapy request. Include all information that supports the request. Call the fiscal agent therapy consultant, if appropriate, before submitting the amendment form to discuss the pertinent issues. If the amendment is approved, the approval date is the date when the amendment request is received by the fiscal agent. It must be received within two weeks of the date the prior authorization is signed by the consultant (process date) on the original PA/RF.
- ✓ If a prior authorization has been denied, providers may, if appropriate, call the fiscal agent consultant to discuss the decision. If the fiscal agent consultant changes the decision based on additional clarifying information, a new prior authorization must be submitted with the additional documentation the consultant requires to change the denial. This information must be submitted to the fiscal agent within two weeks of the process date on the denied PA/RF. This request may be backdated to the first fiscal agent receipt date of the original denied prior authorization when the grant date is requested and the denied request is referred to in writing.

If the consultant does not change the denial, the *recipient* has the right to appeal through the fair hearing process as instructed in the denial letter. Recipients are notified of the denial and their right to appeal in writing.

Amending Approved Prior Authorization Requests

When medically necessary, providers may request amendments of valid prior authorizations to change the frequency of treatment, the specific treatment codes, or the grant or expiration dates. Changes to the original prior authorization request are based on changes in the recipient's medical condition (i.e., necessary increases or decreases in frequency, a different array of treatment codes found in the plan of care or extending the expiration date).

Valid prior authorizations are not amended to accommodate vacations or leaves of absence by either the recipient or provider. Prior authorization expiration dates may be amended up to one month beyond the original expiration date. The amendments may be done if the services are medically necessary and will be discontinued after a brief extension of the therapy services. However, if therapy is continued, it is recommended that a new prior authorization be submitted rather than go through the amendment process.

Providers amending prior authorization requests must do all of the following:

- ✓ Write a letter to the fiscal agent requesting an amendment to the approved prior authorization.

G. Additional Information Relating to Prior Authorization (continued)

- ✓ In sufficient detail, describe the reason for the request so Wisconsin Medicaid can determine its medical necessity.
- ✓ Describe in detail the specific change requested.
- ✓ Attach a copy of the approved prior authorization.
- ✓ Attach supporting clinical documentation.

Send the amendment request to:

EDS
Attn: Prior Authorization, Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Amendment Request Approval Criteria
Amendment requests may be approved if the request is medically necessary under HSS 101 (96m), Wis. Admin. Code, submitted before the date of the requested change, and fully explained and documented in the request. Clinical documentation of the medical necessity amendment request is required.

Following is an example of an amendment request that may be approved:

- ✓ A brief (less than one month) extension of the original approved prior authorization is requested. The brief extension occurs only when the recipient's medical condition is reasonably anticipated to improve during the extension period such that similar services will not be medically necessary following the requested extension (i.e. the provider is not expected to submit a new prior authorization request for similar services following the extension).

Amendment Request Denial Criteria
Amendment requests are denied if they are not medically necessary.

Requests are denied for the following reasons:

- ✓ Solely for the convenience of the recipient, the recipient's family, or the provider.
- ✓ Not received before the date of the requested change.
- ✓ Extending an approved prior authorization expiration date when the recipient's medical condition changes significantly, requiring a new plan of care.
- ✓ where similar services are expected to be medically necessary following the expiration date of the original approved prior authorization.

Note: At the end of a possible extension period, providers must submit a new prior authorization request instead of requesting an extension if one of the following occurs:

- → The recipient's medical condition changes significantly requiring a new plan of care
- → Similar services are expected to be medically necessary.

G. Additional Information Relating to Prior Authorization (continued)

Obtaining Prior Authorization

Sample prior authorization request forms along with their completion and submittal instructions are in Appendices 9 through 13 of this handbook.

Send completed prior authorization request forms to:

EDS
Attn: Prior Authorization Unit - Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Order prior authorization request forms from:

EDS
Attn: Form Reorder
6406 Bridge Road
Madison, WI 53784-0003

Please specify the prior authorization form and number desired. Reordered forms are included with form shipments. Do not request prior authorization forms by telephone.

H. HealthCheck "Other Services"

Medically necessary services which are not otherwise covered by Wisconsin Medicaid may be covered if they are provided to a recipient under age 21 as a result of a HealthCheck examination.

To request prior authorization for HealthCheck "Other Services," do:

- ✓ Submit a PA/RF.
  - → Indicate on the PA/RF that the request is for HealthCheck "Other Services."
  - → Wisconsin Medicaid assigns a procedure code if the service is approved.
- ✓ Submit the Prior Authorization Therapy Attachment (PA/TA) which clarifies the service and medical necessity of the service with the PA/RF.
- ✓ Include a signed and dated statement by the HealthCheck screener or an indication that the recipient received a HealthCheck screen.

The screen must have been performed within one year of the date of fiscal agent receipt of the prior authorization request. Also, the service must be a covered service under federal regulations.